
State:	Arkansas	Filing Company:	American United Life Insurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	EOI-MIB		
Project Name/Number:	EOI-MIB/G-23223-EOI		

Filing at a Glance

Company:	American United Life Insurance Company
Product Name:	EOI-MIB
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	09/07/2012
SERFF Tr Num:	AULD-128675813
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	EOI-MIB LIFE
Implementation	On Approval
Date Requested:	
Author(s):	Bridget McGill, Angie Neville, Danita Ragland-Hatton
Reviewer(s):	Linda Bird (primary)
Disposition Date:	09/12/2012
Disposition Status:	Approved-Closed
Implementation Date:	
State Filing Description:	

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: EOI-MIB
Project Name/Number: EOI-MIB/G-23223-EOI

Filing Company: American United Life Insurance Company

General Information

Project Name: EOI-MIB
 Project Number: G-23223-EOI
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:

Status of Filing in Domicile: Pending
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Individual Market Type:
 Filing Status Changed: 09/12/2012
 State Status Changed: 09/12/2012
 Created By: Danita Ragland-Hatton
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Danita Ragland-Hatton

Filing Description:
 September 7, 2012

Jay Bradford. Commissioner
 Department of Insurance
 State of Arkansas
 1200 West Third Street
 Little Rock, AR 72201-1904

Re: American United Life Insurance Company - NAIC #60895
 Statement of Insurability, G-23223-EOI
 Underwriting Information, G-23728
 Statement of Insurability - to be used with Group Life and Disability Income Insurance and Individual Life Insurance forms
 Underwriting Information - to be used with Individual Life Insurance forms

Dear Commissioner Bradford:

Attached for information is the Statement of Insurability and the Underwriting Information. An additional MIB authorization has been added as required by MIB.

The forms, Statement of Insurability and Underwriting Information, have not been used or issued. The forms were originally filed as follows:

Filing SERFF # Approval Date
 Statement of Insurability -Life filing
 Statement of Insurability –Disability filing AULD-127685512
 AULD-127685909 10-10-2011
 10-12-2011
 Underwriting Information AULD-128201852 3-29-2012

The change required by MIB is to include language in our MIB authorization that elicits an applicant's express written consent to report information to MIB. The following sentence has been added to the Authorization and Acknowledgement section: I/we authorize American United Life Insurance Company (AUL) and its reinsurers to make a brief report of my personal health information to MIB. So you can easily determine what was added, the sentence has been underlined in each form.

This filing is for the sole purpose of revising the MIB authorization language. We certify that this is the only language change made to the forms, Statement of Insurability and Underwriting Information.

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: EOI-MIB
Project Name/Number: EOI-MIB/G-23223-EOI

Filing Company: American United Life Insurance Company

Please acknowledge approval of these updated forms via SERFF.

You may call me at 1-877-285-7660 (ext 1809) or contact me by e-mail at productcompliance.corporatecompliance@oneamerica.com if you have any questions. Thank you for your assistance with this filing.

Sincerely,

Bridget McGill
Senior Contract Analyst
Corporate Compliance and Market Conduct

Company and Contact

Filing Contact Information

Bridget McGill, Sr. Contract Analyst
One American Square
Indianapolis, IN 46206

Bridget.McGill@oneamerica.com
317-285-1809 [Phone]

Filing Company Information

American United Life Insurance Company
One American Square
P.O. Box 7127
Indianapolis, IN 46206
(877) 285-7660 ext. [Phone]

CoCode: 60895
Group Code: 619
Group Name:
FEIN Number: 35-0145825

State of Domicile: Indiana
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: 2 forms x \$50 = \$100
Per Company: No

Company	Amount	Date Processed	Transaction #
American United Life Insurance Company	\$100.00	09/07/2012	62483269

SERFF Tracking #:	AULD-128675813	State Tracking #:		Company Tracking #:	EOI-MIB LIFE
State:	Arkansas	Filing Company:	American United Life Insurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	EOI-MIB				
Project Name/Number:	EOI-MIB/G-23223-EOI				

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/12/2012	09/12/2012

SERFF Tracking #:	AULD-128675813	State Tracking #:		Company Tracking #:	EOI-MIB LIFE
State:	Arkansas	Filing Company:	American United Life Insurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	EOI-MIB				
Project Name/Number:	EOI-MIB/G-23223-EOI				

Disposition

Disposition Date: 09/12/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variables - EOI		Yes
Supporting Document	Statement of Variables - Underwriting Information		Yes
Form	Statement of Insurability		Yes
Form	Underwriting Information		Yes

State:	Arkansas	Filing Company:	American United Life Insurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	EOI-MIB		
Project Name/Number:	EOI-MIB/G-23223-EOI		

Form Schedule

Lead Form Number: G-23223-EOI							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		G-23223-EOI	AEF	Statement of Insurability	Initial:	50.200	G-23223-EOI 8-6-12.pdf
2		G-23728	AEF	Underwriting Information	Initial:	54.100	G-23728 8-6-12.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

Statement of Insurability

Products and financial services provided by
American United Life Insurance Company®
a ONEAMERICA® company
One American Square, P.O. Box 368
Indianapolis, IN 46206-0368
1-800-553-5318



Section A: Proposed Insured (complete Statement of Insurability)

Proposed Insured Name: _____
Driver's License Number _____ State where Issued _____
Height _____ ft. _____ in. Weight _____ lbs. ☐ Gained ☐ Lost _____ lbs. In Past Year

**Spouse and/or Child(ren) must complete Statement of Insurability if required for Group Coverage.
Whole Life Insurance Coverage not available for Spouse/Children.**

Spouse/Partner Name (Last, First, Middle)	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth Date _____	Birth Place _____
	Driver's License # _____	State where Issued _____
	Height _____ Weight _____	Authorized to Reside in U.S. <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Name (Last, First)	Relationship to You _____	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth Date _____	Birth Place _____
	Height _____ Weight _____	Authorized to Reside in U.S. <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Name (Last, First)	Relationship to You _____	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth Date _____	Birth Place _____
	Height _____ Weight _____	Authorized to Reside in U.S. <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Name (Last, First)	Relationship to You _____	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth Date _____	Birth Place _____
	Height _____ Weight _____	Authorized to Reside in U.S. <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Name (Last, First)	Relationship to You _____	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gender <input type="checkbox"/> M <input type="checkbox"/> F Birth Date _____	Birth Place _____
	Height _____ Weight _____	Authorized to Reside in U.S. <input type="checkbox"/> Yes <input type="checkbox"/> No

Underwriting Information

Section B: Health Questions

1. Within the past 7 years, has any applicant for insurance been diagnosed or treated by a physician or medical professional, tested positive for the presence of, or taken prescribed medicine for the following: (Circle conditions that apply in multi-condition questions, and provide full details to any "yes" response in Section 4.)

	Proposed Insured	Spouse	Children
a. Cancer, malignancy, or tumor of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes, thyroid, or other glandular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Chest pain, angina, or heart attack; heart disease/disorder or murmur, peripheral vascular disease, elevated cholesterol or triglycerides?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. High blood pressure or hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Anemia, bleeding disorder, clotting disorder or other blood disease or disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Neurological or brain disorder, seizures, epilepsy, paralysis, multiple sclerosis, ALS or Lou Gehrig's disease, Parkinson's disease, Alzheimer's, other forms of dementia/cognitive disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Stomach or intestinal disorder, Crohn's, irritable bowel disorder, diverticulitis, GERD/reflux?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Kidney, urinary bladder, gallbladder, pancreas, liver disorder or hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Psychological, psychiatric, or emotional disorder, depression, anxiety, stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Lung or respiratory disorder/disease, shortness of breath, asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Neuromuscular, musculoskeletal disorders, lupus, arthritis, neck-, back-, knee- or foot disorders, other joint disorder, fibromyalgia, or chronic fatigue syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Skin or lymph node disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Eye, ear, nose, mouth, or throat disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or any immune deficiency related disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
p. Prostate or testicular disorder, female reproductive organ disorder, or sexually transmitted disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section B: Health Questions (continued)

2. Within the past 5 years, has any applicant for insurance: (Circle information that applies in multi-part questions, and provide full details to any "yes" response in Section 4.)

	Proposed Insured	Spouse	Children
a. Had a checkup or consultation with a physician or medical practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Been an inpatient or outpatient in a hospital, clinic, or medical facility or any similar entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Taken in the past, or is currently taking, any prescription medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Had an EKG, x-ray, blood study, urinalysis, treadmill, heart cath, MRI, CT scan, biopsy, or any other diagnostic testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Made a claim or received benefits, compensation, or pension for any injury, sickness, disability, or impaired condition, and/or been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Received or been instructed to seek treatment for use or abuse of: <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates, inhalants, or any other habit-forming drug or substance, whether prescribed or non-prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Had any surgical procedure for weight loss? If so what was date of surgery? _____ What was your pre-surgery weight? _____ lbs.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Been rejected, declined, rated, postponed, or modified for life or disability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Had any illness, disease, injury, operation, or treatment other than stated above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Currently, is any Applicant: (Provide details to any "yes" response in Section 4.)

a. Pregnant? Expected delivery date: _____ (List current or past complications or high risk issues, including but not limited to pregnancy related high blood pressure, diabetes multiple gestations, i.e., twins, etc in Section 4.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Has any applicant ever used any nicotine (including substitutes such as gum, patch, etc.) and/or tobacco products? If Yes, provide detail below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name _____

1. ☐ Present ☐ Former

2. Type of nicotine or tobacco used: _____

3. When did the applicant quit using all forms of nicotine (including substitutes) or tobacco? _____ month/year
If more than one applicant has used nicotine, provide full details in Section 4.

4. Describe details of each "yes" response from Questions 1-3. If needed, use separate sheet of paper.

Name	Question No.	Details of injury, illness, or disorder	Date	Name of Physician, Hospital, or Other Provider

Authorization and Acknowledgement

[I/we] authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmaceutical databases, DMV and the MIB to give to American United Life Insurance Company® (AUL) and its reinsurers any of the following information about me [and my spouse and/or my dependents, if they are to be insured]: facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying record, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. **This authorization does not authorize the release of genetic screening or testing results.** All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. This data will be used to determine eligibility for insurance.

A photocopy of this form shall be as valid as the original. [I/we] authorize American United Life Insurance Company (AUL) and its reinsurers to make a brief report of my personal health information to MIB. This authorization will be valid for 24 months from the date shown below. In Arizona, this authorization is limited to 180-days for disclosure of HIV-related information. [I/we] understand that any person requesting to be insured may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the Acquired Immune Deficiency Syndrome virus. If an investigative consumer report is made, [I/we] can choose to be interviewed and to receive a copy of the report upon request.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of [my/our] knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct and benefits under any policy will be paid only if AUL or its claims administrator decides in its discretion the applicant is entitled to them; 3) [I/we] certify that all notices contained herein were read and understood prior to [my/our] completion of this form; 4) has received and kept a full and complete copy of this Statement of Insurability, as well as any changed or updated copies involved in the underwriting of this request for insurance; and 5) has received the Notice of Insurance Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice and this Authorization and Acknowledgment.

Signatures

Signature of Proposed Insured / Employee *Mo. / Day / Year*

Printed Name of Proposed Insured / Employee

Signature of Spouse / Partner *Mo. / Day / Year*

Printed Name of Spouse / Partner

Signature of Dependent Child Age 18+ *Mo. / Day / Year*

Printed Name of Dependent Child Age 18+

Underwriting Information

Products and financial services provided by
American United Life Insurance Company®
a ONEAMERICA® company
One American Square, P.O. Box 368
Indianapolis, IN 46206-0368
1-800-553-5318



Please Provide the Following Information

Proposed Insured Name: _____

Driver's License Number: _____ State Where Issued: _____

During the last 12 months, has the proposed insured ever used any nicotine (*including substitutes such as gum, patch, etc.*) and/or tobacco products? ☐ Yes ☐ No

1. During the last 3 years, has the proposed insured plead guilty to or been convicted of driving under the influence of alcohol or drugs, or had your license suspended or revoked? ☐ Yes ☐ No

2. Has the proposed insured ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (*AIDS virus*) or Acquired Immune Deficiency Syndrome (*AIDS*)? ☐ Yes ☐ No

For questions 3 and 4, the Proposed Insured need not include colds, minor viruses or minor injuries which prevented normal activities for 5 consecutive days or less.

3. During the last 12 months, has the proposed insured been ☐ unable to work ☐ or perform the normal activities of like age and gender, or been confined at home? ☐ Yes ☐ No

4. During the last 12 months, has the proposed insured been treated, examined or advised by a member of the medical profession; or been an inpatient or outpatient in a hospital, clinic or medical facility; or similar entity? ☐ Yes ☐ No

If answer to ☐ either questions 3 or 4 ☐ is "Yes", please provide dates and details below.

Fraud Notice

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Authorization and Acknowledgement

I authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmaceutical databases, DMV and the MIB to give to American United Life Insurance Company® (AUL) and its reinsurers any of the following information about me: facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. **This authorization does not authorize the release of genetic screening or testing results.** All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. I authorize American United Life Insurance Company (AUL) and its reinsurers to make a brief report of my personal health information to MIB. This authorization will be valid for 24 months from the date shown below. If an investigative consumer report is made, I can choose to be interviewed and to receive a copy of the report upon request.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of my knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct and benefits under any policy will be paid only if AUL or its claims administrator decides in its discretion the applicant is entitled to them; 3) I certify that all notices contained herein were read and understood prior to my completion of this form; 4) has received and kept a full and complete copy of this Underwriting Information form, as well as any changed or updated copies involved in the underwriting of this request for insurance; and 5) has received the Notice of Insurance Practices, the Medical Bureau Notice, the Fair Credit Reporting Act Notice and this Authorization and Acknowledgement.

Signature

Signature of Proposed Insured / Employee

Mo. / Day / Year

Printed Name of Proposed Insured / Employee

SERFF Tracking #:	AULD-128675813	State Tracking #:		Company Tracking #:	EOI-MIB LIFE
State:	Arkansas	Filing Company:	American United Life Insurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	EOI-MIB				
Project Name/Number:	EOI-MIB/G-23223-EOI				

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Cert of Compliance AR.pdf			
READCERT.pdf			

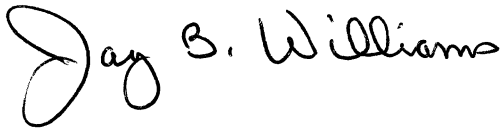
		Item Status:	Status Date:
Satisfied - Item:	Statement of Variables - EOI		
Comments:			
Attachment(s):			
Statement of Variables - G-23223-EOI.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variables - Underwriting Information		
Comments:			
Attachment(s):			
Statement of Variables - G-23728.pdf			

CERTIFICATE OF COMPLIANCE

State of Arkansas

I, Jay B. Williams, Vice President Chief Compliance Officer, of the AMERICAN UNITED LIFE INSURANCE COMPANY®, hereby certify that the enclosed Forms comply with all Insurance Statutes, Regulations, and Departmental requirements of the State of Arkansas.

A handwritten signature in black ink that reads "Jay B. Williams". The signature is written in a cursive style with a large, stylized initial "J".

Jay B. Williams
Vice President Chief Compliance Officer

Date: September 7, 2012

CERTIFICATE OF READABILITY

I, Jay B. Williams, Vice President and Director of Compliance of American United Life Insurance Company, hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements.

FORMS

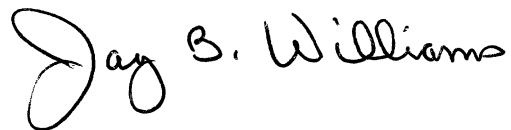
READABILITY SCORE

G-23728

54.1

G-23223-EOI

50.2

A handwritten signature in black ink that reads "Jay B. Williams". The signature is written in a cursive style with a large, stylized initial "J".

September 7, 2012

Jay B. Williams
Vice President and Director of Compliance

STATEMENT OF VARIABLES
G-23223-EOI

FORM NUMBER	SECTION TITLE	PROVISION/ DESCRIPTION	BRACKETED VARIABLES EXPLANATION
G-23223-EOI	Statement of Insurability	Company address/phone number	Bracketed for ease in updating as need arises should there be a change in the company address or phone number.
“	“	OneAmerica (logo)	Bracketed for ease in updating the logo in case it is changed.
“	Section A	Spouse and children	Bracketed so the spouse and children questions may be deleted if evidence of insurability information for spouse and children are not applicable. Bracketed for ease in updating as need arises whenever there is a change in product(s) offered to the spouse and children– the change could be in a product name or it could be a new product that has been filed and approved by the state
“	Section B	Spouse and Children columns	Bracketed so the spouse and children area may be deleted if evidence of insurability for spouse and children are not applicable.
“	Authorization and Acknowledgement	“I/we”, “my/our” and “(and my spouse and/or my dependents, if they are to be insured)”	Bracketed so the references to spouse and children may be deleted if evidence of insurability for spouse and children are not applicable.
“	Signatures	Signatures for Spouse and children	Bracketed so the spouse and children signature items may be deleted if evidence of insurability for spouse and children are not applicable.

STATEMENT OF VARIABLES
G-23728

FORM NUMBER	SECTION TITLE	PROVISION/ DESCRIPTION	BRACKETED VARIABLES EXPLANATION
G-23728	Underwriting Information	Company address/phone number	Bracketed for ease in updating as need arises should there be a change in the company address or phone number.
“	“	OneAmerica (logo)	Bracketed for ease in updating the logo in case it is changed.
“		During the last 12 months, has the proposed insured been [unable to work,]or perform the normal activities of like age and gender, or been confined at home?	Bracketed to allow for the following variation change: During the last 12 months, has the proposed insured been [unable to work, <u>attend school</u>]or perform the normal activities of like age and gender, or been confined at home? The “attend school” wording may be needed for some employer groups, underwriting would determine where “attend school” wording is appropriate.
“		If answer to [either questions 3 or 4] is “Yes”, please provide dates and details below.	Bracketed to allow for variations regarding which questions, 1, 2, 3, or 4, need dates and details. Underwriting would determine where dates and details for questions may be appropriate.